

Gender Affirming Surgery

Policy MP-002

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Disclaimer:

1. Policies are subject to change in accordance with State and Federal notice requirements.
2. Policies outline coverage determinations for U of U Health Plans Commercial, Healthy U (Medicaid) and Advantage U (Medicare) plans. Refer to the "Policy" section for more information.
3. **This Medical Policy does not guarantee coverage or payment of the service. The service must be a benefit in the member's plan and the member must be eligible for coverage at the time of service. Additional payment guidelines may be applied that are not included in this policy.**

Description:

Gender affirming surgery is part of the spectrum of care considered for individuals with gender dysphoria, a condition in which a person feels a strong and persistent identification with the opposite gender accompanied with a severe sense of discomfort in their own gender. People with gender dysphoria often report a feeling of being born the wrong gender they physically appear to be. Gender affirming surgery is not a single procedure, but part of a complex process involving multiple medical, psychiatric, and surgical modalities working in conjunction with each other and the patient to achieve successful behavioral and medical outcomes.

Policy Statement and Criteria

1. Commercial Plans

Criteria is divided by Breast/Chest Surgery and Genital Surgery

U of U Health Plans covers gender affirming surgery when all of the following criteria are met:

Criteria for Breast/Chest Surgery

- A. Patient is 18 years or older;
- B. The requested procedure is being performed by qualified physicians at an approved Center of Excellence with experience in the following services;
- C. The patient has been diagnosed with persistent and documented Gender Dysphoria;

- D. Documentation that no significant medical or mental health concerns are present; If concerns are present, then documentation that they are reasonably controlled;
- E. Capacity to make a fully informed decision and to give consent for treatment;
- F. One letter provided by treating provider documenting the following:
 - i. The patient's general identifying characteristics; and
 - ii. The initial and evolving gender, sexual, and other psychiatric diagnoses; and
 - iii. The duration of the patient's professional relationship with the provider or previous providers including the type of psychotherapy or evaluation that the patient underwent; and
 - iv. The eligibility criteria that have been met and the behavioral health professional's rationale for surgery; and
 - v. The degree to which the patient has followed the eligibility criteria to date and the likelihood of future compliance; and
 - vi. Whether the author of the report is part of a gender team.

Criteria for Genital Surgery

Hysterectomy and Salpingo-Oophorectomy in FtM Patients and Orchiectomy in MtF Patients:

- A. Patient is 18 years or older;
- B. The requested procedure is being performed by qualified physicians at an approved Center of Excellence with experience in the following services;
- C. The patient has been diagnosed with persistent and well documented Gender Dysphoria;
- D. Documentation that significant medical or mental health concerns, if present, are well controlled;
- E. For these patients without a medical contraindication, the patient has undergone a minimum of 12 months of continuous hormonal therapy;
- F. The patient has completed a minimum of 12 months of successfully living in the gender role that is congruent with their gender identity;
- G. Two letters provided by treating providers:
 - i. The first letter from the patient's physician or behavioral health provider, documenting the following:
 - a) The patient's general identifying characteristics; and
 - b) The initial and evolving gender, sexual, and other psychiatric diagnoses; and

- c) The duration of the patient’s professional relationship with the provider or previous providers including the type of psychotherapy or evaluation that the patient underwent; and
 - d) The eligibility criteria that have been met and the behavioral health professional’s rationale for surgery; and
 - e) The degree to which the patient has followed the eligibility criteria to date and the likelihood of future compliance; and
 - f) Whether the author of the report is part of a gender team.
- ii. A second letter from a different physician or behavioral health provider familiar with the patient’s treatment and the psychological aspects of Gender Dysphoria, corroborating the information provided in the first letter;
 - iii. When one of the signatories on the letters indicated above is not the treating surgeon, documentation (letter or clinical notes) from the treating surgical team confirming that they have personally communicated with the treating therapist and/or physician or reviewed signed reports, as well as the patient, and confirming that the patient meets the above criteria, understands the ramifications and possible complications of surgery, and that the surgeon feels that the patient is likely to benefit from surgery.

Metoidioplasty or Phalloplasty in FtM Patients and Vaginoplasty in MtF Patients:

- A. Patient is 18 years or older;
- B. The requested procedure is being performed by qualified physicians at an approved Center of Excellence with experience in the following services;
- C. The patient has been diagnosed with persistent and well documented Gender Dysphoria;
- D. For these patients without a medical contraindication, the patient has undergone a minimum of 12 months of continuous hormonal therapy;
- E. Two letters provided by treating providers:
 - i. The first letter from the patient’s physician or behavioral health provider, documenting the following:
 - a) The patient’s general identifying characteristics; and
 - b) The initial and evolving gender, sexual, and other psychiatric diagnoses; and
 - c) The duration of the patient’s professional relationship with the provider or previous providers including the type of psychotherapy or evaluation that the patient underwent; and

- d) The eligibility criteria that have been met and the behavioral health professional's rationale for surgery; and
 - e) The degree to which the patient has followed the eligibility criteria to date and the likelihood of future compliance; and
 - f) Whether the author of the report is part of a gender team.
- ii. A second letter from a different physician or behavioral health provider familiar with the patient's treatment and the psychological aspects of Gender Dysphoria, corroborating the information provided in the first letter;
 - iii. When one of the signatories on the letters indicated above is not the treating surgeon, documentation (letter or clinical notes) from the treating surgical team confirming that they have personally communicated with the treating therapist and/or physician or reviewed signed reports, as well as the patient, and confirming that the patient meets the above criteria, understands the ramifications and possible complications of surgery, and that the surgeon feels that the patient is likely to benefit from surgery.

Gender affirming surgery may include any of the following procedures:

Male-to-Female Procedures:

- Breast implantation/augmentation
- Orchiectomy
- Penectomy
- Vaginoplasty and associate hair removal if necessary for external skin transpositioned into area
- Clitoroplasty
- Labiaplasty

Female-to- Male Procedures:

- Subcutaneous mastectomy without nipple rearrangement surgery
- Hysterectomy
- Salpingo-oophorectomy
- Vaginectomy
- Metoidioplasty
- Scrotoplasty
- Urethroplasty
- Phalloplasty
- Placement of testicular prostheses

In the case of non-binary individuals, above surgeries will be considered to align their gender preference.

Gender affirming surgery is **not covered** and considered cosmetic when used to improve the gender specific appearance of a patient who has undergone or is planning to undergo gender affirming surgery.

The following surgeries are considered cosmetic (may not be all inclusive):

- 1) Abdominoplasty
- 2) Blepharoplasty
- 3) Brow Lift
- 4) Cheek/Malar Implants
- 5) Chin/Nose Implants
- 6) Collagen Injections
- 7) Facial bone reconstruction
- 8) Face lift
- 9) Forehead Lift
- 10) Calf Lift
- 11) Hair removal/hairplasty including medications that cause hair loss or growth unless area of hair removal is skin taken from external source used for creation of artificial vagina
- 12) Hair Transplantation
- 13) Lip Reduction
- 14) Liposuction
- 15) Mastopexy
- 16) Neck Tightening
- 17) Pectoral Implants
- 18) Reduction thyroid chondroplasty
- 19) Rhinoplasty
- 20) Voice modification surgery
- 21) Voice Therapy/Lessons

It is important to note this policy **DOES NOT** apply to individuals with congenital deformities/anomalies or genetic abnormalities resulting in genitalia requiring correction.

2. Medicaid Plans

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicaid policies

and coverage, please visit their website at:

<http://health.utah.gov/medicaid/manuals/directory.php> or the [Utah Medicaid code Look-Up tool](#)

CPT/HCPCS codes covered by Utah State Medicaid may still require further evaluation to determine medical necessity for coverage.

3. Medicare Plans

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicare policies and coverage, please visit their search website at:

<http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp&> or [the manual website](#)

Clinical Rationale

Gender Dysphoria, previously referred to as Gender Identity Disorder or transsexualism, is a condition wherein an individual's experienced/expressed gender is incongruent with the assigned gender and causes clinically significant distress and impairment. Gender dysphoria should not be confused with cross dressing (Transvestitism), refusal to accept non-heterosexual orientation, psychotic delusions or personality disorders.

Gender-affirming surgical treatment differs depending upon the assigned sex at birth of the patient and each patient's needs to diminish gender dysphoria. Not every patient wants every type of gender-affirming surgery. Male-to-female patients, also known as "transwomen," may seek genital surgery (removal of the testicles only; removal of testicles and penis and the creation of pseudo vagina, clitoris, and labia) or facial feminization surgery (tracheal shave). Female-to-male patients, known as "transmen," may seek genital surgery to remove the uterus, ovaries, and vagina, creation of a neophallus, and scrotum with scrotal prostheses) and "top surgery", also called chest masculinization surgery with bilateral mastectomy.

The guideline criteria above are based upon; 1) the Diagnostic and Statistical manual of Mental Disorders, Fifth Edition, (DSM-V, 2013) criteria for the diagnosis of Gender Dysphoria; and 2) the Standards of Care (SOC) for Transgender and Gender Non-Conforming People, Version 7, published by the World Professional Association for Transgender Health (2012). Both of these references are widely accepted as definitive documents in the area of Gender Dysphoria treatment and cited in numerous articles by respected authors. The SOC criteria have been adopted in several countries as the standard of care for the treatment of Gender Dysphoria, including hormone therapy and gender affirming surgery.

The criteria of the SOC are supported by evidence-based peer-reviewed journal publications. Several studies have shown that extensive long-term trials of hormonal therapy and real-life experiences, as well as social support and acceptance by peer and family groups, greatly improve psychological and social outcomes in patients undergoing gender affirming surgery (Eldh, 1997; Landen, 1998). A study reported by Monstrey and colleagues (2001) described the importance of close cooperation between the many medical and behavioral specialties required for proper treatment of patients with Gender Dysphoria who wish to undergo gender affirming surgery. Similar findings were reported earlier by

Schlatterer et al. in 1996. One study of 188 patients undergoing gender affirming surgery found that dissatisfaction with surgery was highly associated with sexual preference, psychological co-morbidity, and poor preoperative body image and satisfaction (Smith, 2005).

Undertaking gender affirming surgery is obviously a very serious decision. The procedures present significant medical and psychological risks, and results are irreversible. A step-wise approach to therapy for Gender Dysphoria, including accurate diagnosis and long-term treatment by multidisciplinary team including behavioral, medical and surgical specialists, has been shown to provide the best results. As with any treatment including psychiatric disorders, a thorough behavioral analysis by a qualified practitioner is needed. Once a diagnosis of Gender Dysphoria is established, treatment with hormone therapy and establishment of real-life transgender experience may be warranted. Gender affirming surgery should be considered only after such trials have been undertaken, evaluated and confirmed. Hormone therapy should be administered under on-going medical supervision and is important in beginning the gender transition process by altering body hair, breast size, skin appearance and texture, body fat distribution, and the size and function of sex organs. Additionally, real-life experience is important to validate the patient's desire and ability to incorporate into their desired gender role within their social network and daily environment. This generally involves gender-specific appearance (clothing, hairstyle, etc.), involvement in various activities in the desired gender role including work or academic settings, legal acquisition of a gender appropriate first name, and acknowledgement by others of their new gender role.

Once these treatments steps have been established and stable for at least 12 months, a patient may be considered for gender affirming surgery.

For both transmen and transwomen, additional surgeries have been proposed to improve the gender appropriate appearance of the patient. Procedures such as breast augmentation, liposuction, Adam's apple reduction (tracheal shave), rhinoplasty, facial reconstruction, and others have no medically necessary role in gender identification and are considered cosmetic in nature.

The World Professional Association for Transgender Health (WPATH) is a multidisciplinary professional society representing the specialties of medicine, psychology, social sciences and law that has published clinical guidelines regarding health services for patients with gender disorders. In 2012, WPATH updated their evidence and consensus-based guideline regarding, the Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming Peoples.

WPATH guidelines indicate that surgical treatments can be initiated by a referral from a qualified mental health professional. One or two referrals may be required depending upon the type of surgery requested. "The mental health professional provides documentation—in the chart and/or referral letter—of the patient's personal and treatment history, progress, and eligibility." WPATH guidelines specifically recommend the following:

- One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).
- Two referrals—from qualified mental health professionals who have independently assessed the patient—are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries).

WPATH lists the following criteria for mastectomy and creation of a male chest in FTM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (or with 2-parent consent);

4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a prerequisite.

WPATH lists the following criteria for genital surgery:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be reasonably well controlled; and
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual).

In addition, WPATH made specific recommendations regarding breast augmentation procedures:

The WPATH guideline recommends MTF patients undergo feminizing hormone therapy for a minimum of 12 months prior to augmentation surgery and lists specific criteria for breast augmentation (implants/lipofilling).

However, the classification of breast augmentation as a cosmetic versus reconstructive procedure has remained controversial. WPATH guidelines note that although breast appearance may be considered an important secondary sex characteristic, opinions diverge regarding whether augmentation is considered cosmetic or reconstructive. In addition, WPATH indicates that, "breast presence or size is not involved in the legal definitions of sex and gender and is not necessary for reproduction."

In 2009, the Endocrine Society in conjunction with European Society of Endocrinology, European Society for Pediatric Endocrinology, Lawson Wilkins Pediatric Endocrine Society, and World Professional Association, published the only evidence-based guidelines regarding the treatment of transsexual persons. The guideline employed transparent methods for evidence review and for rating the quality of evidence. All recommendations were based upon evidence which was rated to be low quality. These guidelines were updated in 2017. The consortium made the following recommendations:

- 1) We recommend that a patient pursue genital gender affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being.
- 2) We advise that clinicians approve genital genderaffirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated.
- 3) We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery.
- 4) We recommend that clinicians refer hormone treated transgender individuals for genital surgery when:
 - (a) the individual has had a satisfactory social role change, (b) the individual is satisfied about the hormonal effects, and (c) the individual desires definitive surgical changes.

- 5) We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country.
- 6) We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual.
- 7) There is insufficient evidence to recommend a specific age requirement.

Coding for Breast and Nipple Reconstruction. The CPT codes for mastectomy (CPT codes 19303 and 19304) are for breast cancer, and are not appropriate to bill for reduction mammoplasty for female to male (transmasculine) gender affirmation surgery. CPT 2020 states that “Mastectomy procedures (with the exception of gynecomastia [19300]) are performed either for treatment or prevention of breast cancer” and that “Code 19303 describes total removal of ipsilateral breast tissue with or without removal of skin and/or nipples (eg, nipple-sparing), for treatment or prevention of breast cancer.” There are important differences between a mastectomy for breast cancer and a mastectomy for gender affirmation. The former requires careful attention to removal of all breast tissue to reduce the risk of cancer. By contrast, careful removal of all breast tissue is not essential in mastectomy for gender affirmation. In mastectomy for gender affirmation, the nipple areola complex typically can be preserved.

Some have tried to justify routinely billing CPT code 19350 for nipple reconstruction at the time of mastectomy for gender affirming based upon the frequent need to reduce the size of the areola to give it a male appearance. However, the nipple reconstruction as defined by CPT code 19350 describes a much more involved procedure than areola reduction. The typical patient vignette for CPT code 19350, according to the AMA, is as follows: “The patient is measured in the standing position to ensure even balanced position for a location of the nipple and areola graft on the right breast. Under local anesthesia, a Skate flap is elevated at the site selected for the nipple reconstruction and constructed. A full-thickness skin graft is taken from the right groin to reconstruct the areola. The right groin donor site is closed primarily in layers.”

The AMA vignette for CPT code 19318 (breast reduction) clarifies that this CPT code includes the work that is necessary to reposition and reshape the nipple to create an aesthetically pleasing result, as is necessary in female to male breast reduction. “The physician reduces the size of the breast, removing wedges of skin and breast tissue from a female patient. The physician makes a circular skin incision above the nipple, in the position to which the nipple will be elevated. Another skin incision is made around the circumference of the nipple. Two incisions are made from the circular cut above the nipple to the fold beneath the breast, one on either side of the nipple, creating a keyhole shaped skin and breast incision. Wedges of skin and breast tissue are removed until the desired size is achieved. Bleeding vessels may be ligated or cauterized. The physician elevates the nipple and its pedicle of subcutaneous tissue to its new position and sutures the nipple pedicle with layered closure. The remaining incision is “repaired with layered closure” (EncoderPro, 2021). CPT code 19350 does not describe the work that is being done, because that code describes the actual construction of a new nipple.

Therefore, U of U Health Plans considers nipple reconstruction, as defined by CPT code 19350, as cosmetic and/or not medically necessary for mastectomy for transmasculine gender affirming, and that CPT code 19318 includes the extra work that may be necessary to reshape the nipple and create an aesthetically pleasing male chest.

Applicable Coding

CPT Codes Covered: For the conditions outlined above for plans with gender affirming supplemental coverage.

CPT Codes

00402	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; reconstructive procedures on breast (eg, reduction or augmentation mammoplasty, muscle flaps)
00926	Anesthesia for procedures on male genitalia (including open urethral procedures); radical orchiectomy, inguinal
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
17380	Electrolysis epilation, each 30 minutes [when done to treat tissue donor sites for a planned phalloplasty or vaginoplasty procedure]
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue [when specified as permanent hair removal by laser to treat tissue donor sites for a planned phalloplasty or vaginoplasty procedure]
19318	Breast reduction
19325	Mammoplasty, augmentation; with prosthetic implant
53430	Urethroplasty, reconstruction of female urethra
54125	Amputation of penis; complete
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55150	Resection of scrotum
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated

55899	Unlisted procedure, male genital system
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57110	Vaginectomy, complete removal of vaginal wall;
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57335	Vaginoplasty for intersex state
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral;

(CPT Codes Not Covered for Gender Affirming Surgery)

19303	Mastectomy, simple, complete
19350	Nipple/areola reconstruction

HCPCS Codes

C1789	Prosthesis, breast (implantable)
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C1813	Prosthesis, penile, inflatable
L8600	Implantable breast prosthesis, silicone or equal
S0189	Testosterone pellet, 75 mg

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The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy.

Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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